LETTER TO THE EDITOR

A WIDER CANADIAN MEDICAL OUTLOOK

To the Editor:

I have just returned from a three-month tour through the islands of the West Indies Federation and some of the territories in West, Central and East Africa which are or have been British. I met only one other Canadian doctor working in these developing countries, but a very large number from Britain, various European countries, and the United States. This is one of several reasons for concluding that Canada and Canadians lack interest in the problems of the emerging tropical countries.

To the West Indian or the African, Canada seems to have all the virtues, combining British stability and fairness with North American energy and initiative. Canada led the way from colony to independent dominion, and has the great prestige of never having been a colonizing or exploiting country. The new countries look to Canada for disinterested help and encouragement which they would not so readily welcome from elsewhere. So far this hope is largely unfulfilled, and, since Canada is not a poor country, one must lay the blame on lack of interest, or lack of a sense of adventure, or just plain smug parochialism.

Dr. Thompson's article on Canadian medical education in your Journal of April 2 tells us that each year in Canada there are about 860 graduates from 12 medical schools. By contrast, Nigeria, with twice Canada's population, has only between seven and eight hundred doctors in the whole country, and has one medical school which is just beginning to graduate classes of 20 to 30 a year. Is there any valid reason why some Canadian graduates should not work, even for a few years, in such places? There is plenty to be done: in mission hospitals, in government services, in the teaching hospitals. Some might even consider a wealth of experience to be some compensation for smaller financial rewards than Canada offers.

Dr. Struthers' paper on pædiatric education has the distinction of being the only contribution to your medical education issue which refers in any way to the problems of other countries or to the possibility of Canadian doctors helping with them. He is perfectly right in his view that the rather precious North American postgraduate training in pædiatrics is impractical for those who are to practise in the tropics. But he goes on to suggest that the "basic physician" in the tropical countries should concentrate at present on problems of prevention, public health, and health education, and that the locally trained doctor—in pædiatrics at least—"should be group-oriented rather than individual-oriented". I disagree with this, because the best way to influence the group is through the individual. Again consider Nigeria. There, almost half the children die before the age of five. Most of the deaths are due to malaria, smallpox, measles, tuberculosis or malnutrition. Four of these are preventable—by vaccination, BCG, malaria prophylaxis, and education in proper diet. But purely preventive measures fail, because the unsophisticated African mother, like many others, takes her child to the doctor when it is sick, and not when it is well. If the child is treated when it is ill, then comes the chance for immunization and for education of the mother. And mothers whose children have been treated and who have learned in this way are the best possible influence in their communities—better than any public health "authorities". It follows that effective prevention of disease in these communities must develop together with hospital and outpatient pædiatric services.

This is where Canada should come in. Doctors interested in pædiatrics are needed *now*—not to plan programs for others to carry out, but to treat sick children and to spread the gospel of health. Not, as Dr. Struthers suggests, "the provision for periods of one or two years of men who have been trained as teachers or investigators, *presumably at the resident level,* who *might* make their teaching abilities available to future medical schools which *might* be established in such areas of economic deprivation (my italics). No. Able young doctors are needed who will pitch in and work, and stick at the job long enough to learn to know these communities and their problems. Maybe some of them would gain the experience to become teachers in the medical schools which are or will be established in the developing countries.

Dr. Struthers' censure of Canadian postgraduate training in pædiatrics could apply equally to obstetrics and gynæcology. Canadian obstetricians must undergo a long and expensive postgraduate training, but as specialists they spend a great deal of their time doing normal obstetrics which could be done equally well by competent general practitioners or by well-trained nurse-midwives. This is partly, but not entirely, the result of Canadian social tradition. Young obstetricians and gynæcologists in Canada might also consider giving service and gaining experience abroad. The (only) consultant gynæcologist in Northern Nigeria repaired 130 vesico-vaginal fistulæ last year. Would a share in this sort of experience not be more attractive than a resident post in which even the repair of an episiotomy is a rare privilege?

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THE LONDON LETTER

(From our own correspondent)

INDUSTRIAL RHEUMATISM UNIT

In its recently published annual report for 1959, the Empire Rheumatism Council announces that it has decided to establish a special unit to make a comprehensive study of the social and economic effects of rheumatic diseases in British industry. The unit will be under the direction of Dr. J. J. R. Duthie of the University of Edinburgh. In making this announcement it is pointed out that among the employed population of Great Britain more than 730,000 persons claim sickness benefit by reason of rheumatism each year, leading to a loss of more than 27 million working days. The study of the geographical distribution of rheumatism has shown that over 80% of cases are located in industrial areas, providing a strong indication that occupational influence may be of greater importance than climatic variations.

Canad. M. A. J.
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MEDICAL ANONYMITY

At long last the British Medical Association has given way on the subject of anonymity in broadcasting. According to a "Report on advertising and the medical profession", published as an appendix to the supplementary annual report of the Council for 1959-60, "the policy of anonymity in all circumstances is no longer tenable and there is no objection to the announcement of a doctor's name" provided this conforms to certain principles. These principles are laid down as follows: "When the objective of publicity for a doctor or a group of doctors is apparent, paramount, and justifiable (a) in the interests of the general public; or (b) in the interests of the medical profession; or (c) as an essential part of providing authoritative information when necessary for the general public". It is allowed that, "when the circumstances of the broadcast specifically require it, mention may be made of the specialty, professorial chair, or office held, but not otherwise of medical appointments held". On the other hand, "a doctor engaged to give a series of talks or appearances is advised to remain anonymous lest the frequency of mention of his name should be held to be unethical" by the General Medical Council.

TOO MANY HOSPITALS?

Amid all the outcry about the lack of new hospitals there is a tendency to overlook the fact that we have incredibly little information as to precisely how many hospital beds we require. The figure suggested in the early days of the National Health Service was around five hospital beds per 1000 population, and the hospital enthusiasts make much play with the fact that the present national average is only 3.1 per 1000 population. According to the Nuffield Provincial Hospitals Trust, however, even this latter figure is too high. In a report published in 1955, based upon a survey in Norwich and Northampton, the Trust suggested that a ratio of about two beds per 1000 population was adequate. That this figure was not very far off the mark is suggested by another report the Trust has just published, based upon a survey carried out in the ship-building town of Barrow. This new report indicates that for Barrow the appropriate ratio of beds is 2.5 per 1000 population. In these price-conscious days, when the mounting cost of the National Health Service is causing so much concern, the significance of these findings is admirably summed up by the authors of the Trust's report: "At present costs (at £5000 per bed in new hospital construction and £1500 for a new council house) even to provide one bed per 1000 population in England and Wales, a total of 45,000 beds, would have meant building 150,000 fewer houses. Again the cost of these beds would represent about one-third of the annual running costs of the National Health Service."

TEENAGER V.D.

A discussion on "venereal disease in the teenager" at the recent annual congress of the Royal Society of Health has focused public attention on a problem which has been worrying many doctors and social workers during the past few years. Dr. A. J. King reported that during the year ended June 30, 1959, 6255 new cases were seen at the Whitechapel Clinic, one of the largest venereal disease clinics in London. Two-thirds of these were infectious cases, and 490 of these were in teenagers. The over-all picture showed that the proportion of women attending the clinic who were under the age of 21 has risen from 16% in 1936 to 21% in 1959. Comparable findings are included in an as yet unpublished study by the British Co-operative Clinic Group, based upon the figures from 147 venereal disease clinics in England and Wales. These show a serious and rising incidence of infection in 1958, compared with 1957, among young people in the 18-19 age-group, which was greater than that for any other group and well above the average increase for the country as a whole. Similarly, at Holloway Prison, teenagers are forming an increasing proportion of prostitutes who are admitted.

According to another speaker, the number of women attending one venereal disease clinic during last year was about double that attending 20 years ago. One in five of those attending was a girl with "a nice office job", compared with one in 25 before the war. It was this same speaker who reported that "most girls admitted to initial sexual acts between the ages of 13 and 16".

WILLIAM A. R. THOMSON

London, May 1960.

OBITUARIES

DR. PIERRE BEGIN, aged 59, died April 18 in Hull, Quebec. Born at St-Louis-de-Pintendre, Lévis, he was educated at Ste-Anne-de-Beaupré and obtained his medical degree from Laval University in 1927. Dr. Bégin practised in Rimouski and Hull.

Surviving are his widow, two sons and three daughters.

DR. JOHN STANHOPE GLADWIN, aged 85, died March 20 in Vancouver. Born in Nova Scotia, he graduated from the University of Pennsylvania. He practised in the coal mining towns of Crowsnest and Fernie, B.C., served in the Boer War and First World War, and practised in Vancouver until his retirement in 1944.

Dr. Gladwin is survived by his widow.

DR. LAURENT GODIN died April 16 in Montreal. Born in 1887 in Côte St-Paul, he received his medical degree from the University of Montreal in 1911. He practised general medicine in Montreal for over 40 years.

Surviving are his widow and one son.

DR. CECIL ULYSSES HOLMES, 85, died April 18. Born in Selkirk, Ont., he graduated from the University of Toronto in 1898. He practised in Hagersville, was medical superintendent of Six Nations Indian Reserve and established a practice in Edmonton, Alta., in 1911. He served as a medical officer in the Canadian Expeditionary Force, returned to private practice in 1918, and was a lecturer in obstetrics at the University of Alberta Medical School. He retired from practice in 1937 and became district administrator of the Department of Veterans Affairs.

Dr. Holmes is survived by one son.